

NOV 24 1930

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

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1. PLACE OF DEATH

County Harrison Registration District No. 334
Township Sherman Primary Registration District No. 5466
City Do St. _____ Ward _____

File No. _____
Registered No. _____

2. FULL NAME

Billie Joe Waterbury

(a) Residence No. _____ St. _____ Ward _____
(Usual place of abode)

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single (Specify the word)

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Y

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 8-26-1930

7. AGE YEARS MONTHS DAYS IT LESS than 1 day, hrs. or min.
0 1 2

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY) Harrison Co. Mo

10. NAME OF FATHER Orcel Waterbury

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) low a

12. MAIDEN NAME OF MOTHER Ida Cutshall

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Missouri

14. INFORMANT Orcel Waterbury
(Address) Bethany Mo

15. FILED 1/10 1930 W J Hamed
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 9-28 1930

17. I HEREBY CERTIFY, That I attended deceased from 9-27, 1930, to 9-28, 1930.
that I last saw h. _____ alive on _____ 19____ and that death occurred, on the date stated above, at 9:45 A m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

acute Bronchopneumonia
107A

(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY)

(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH _____

19. DID AN OPERATION PRECEDE DEATH? DATE OF _____

WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) J. C. Stover M. D.

, 19 (Address) Bethany city Mo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL

Fairview 9-29-1930

20. UNDERTAKER S. W. Hays ADDRESS Bethany Mo

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH.
 County Harrison Registration District No. 334 File No.
 Township Sherman Primary Registration District No. 3466 Registered No.
 City (No.) St. Ward (No.) St. Ward (No.)

2. FULL NAME Billie Joe Waterbury
 (a) Residence No. St. Ward.
 (Usual place of abode) (If nonresident give city or town and State)
 Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX m 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) A

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work
 (b) General nature of industry, business, or establishment in which employed (or employer)
 (c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept 28 1930

17. I HEREBY CERTIFY, That I attended deceased from 19....., to 19....., and that I last saw him alive on 19....., and that death occurred, on the date stated above, at..... m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Acute Broncho Pneumonia
Primary
 (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) none
 (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH.....
 DID AN OPERATION PRECEDE DEATH?..... DATE OF.....
 WAS THERE AN AUTOPSY?.....
 WHAT TEST CONFIRMED DIAGNOSIS?.....
 (Signed)....., M. D.
 , 19 (Address)

PARENTS

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY)

14. INFORMANT (Address)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL

20. UNDERTAKER ADDRESS

15. FILED 9/10, 1930 M J Harned REGISTRAR

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

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1930

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